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BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against**:** **Jason Alan Berryhill, P.A.** **8864 Glori Dawn Dr.** **Orangevale, CA 95662-4554** **Physician Assistant License** **No. PA 22877**, Respondent.	Case No. 950-2020-002761 **A C C U S A T I O N**

PARTIES

1. Rozana Khan (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Physician Assistant Board, Department of Consumer Affairs (Board).

2. On or about March 15, 2013, the Physician Assistant Board issued Physician Assistant License Number PA 22877 to Jason Alan Berryhill, P.A. (Respondent). The Physician Assistant License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2024, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 3527 of the Code states:

> (a) The board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a PA license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board.
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> (b) The board may order the denial of an application for, or the suspension or revocation of, or the imposition of probationary conditions upon, an approved program after a hearing as required in Section 3528 for a violation of this chapter or the regulations adopted pursuant thereto.
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> (c) The board may order the denial of the application for, or the suspension or revocation of, or the imposition of probationary conditions upon, a PA license, after a hearing as required in Section 3528 for unprofessional conduct that includes, except for good cause, the knowing failure of a licensee to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of bloodborne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other bloodborne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the Osteopathic Medical Board of California, the Podiatric Medical Board of California, the Dental Board of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians of the State of California to encourage appropriate consistency in the implementation of this subdivision.
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> The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of bloodborne infectious diseases.
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> (d) The board may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license.
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> (e) The expiration, cancellation, forfeiture, or suspension of a PA license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

5. Section 3528 of the Code states any proceedings involving the denial, suspension, or revocation of the application for licensure or the license of a PA or the application for approval or the approval of an approved program under this chapter shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

6. Section 2234 of the Code, a part of the Medical Practice Act, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
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> (d) Incompetence.
>
> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
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> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

COST RECOVERY

7. Section 125.3 of the Code states, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of

the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL ALLEGATIONS

8. Respondent was employed as a Physician Assistant to provide medical care to patients at Vista Complete Care (Vista), in Auburn, California from approximately 2013 through 2020.

Patient 1

9. Patient 1 was a 49-year-old woman as of 2019. Patient 1 had been a patient of Respondent at Vista for many years. Beginning in January of 2019, Respondent concurrently prescribed two separate opioids and a benzodiazepine to Patient 1 each month between January 2019 and November 2019. The benzodiazepine he prescribed to Patient 1 each month was alprazolam, and the opioids he prescribed to Patient 1 each month were oxycodone and morphine. Respondent failed to document an unusual medical need to concurrently prescribe benzodiazepines and opioids, which would warrant a prescribing combination that has been shown to present particular risks to patients. Respondent further failed to document attempts to limit or taper either of the categories of drugs for the purpose of patient safety.

10. Patient 1 underwent urine drug testing at Vista on or about December 4, 2017, and on or about August 19, 2019. Respondent noted the test results from December 4, 2017, in the medical record, but failed to note the test results from August 19, 2019, in the record. The test from the August 19, 2019, was positive for several substances that Respondent was not prescribing to her, including meprobamate, nordiazepam, oxazepam, temazepam, and noroxycodone. Despite the inconsistencies found on the urine test results, Respondent continued to prescribed oxycodone, morphine and alprazolam.

Patient 2

11. Patient 2 was a 64-year-old woman when she began seeing Respondent for care at Vista in 2018. Patient 2 had a history of lumbar back pain for which she was prescribed the opioids hydrocodone with acetaminophen and oxycodone. During August, September, and October of 2019, Respondent prescribed Patient 2 a 30-day supply of alprazolam, a

benzodiazepine, in addition to two opioids. Patient 2 was 65 years old during these months. During the time Respondent treated Patient 2, he prescribed in excess of 80 milligrams of morphine equivalent per day to her, but failed to refer her to a pain medication specialist for consultation. Respondent failed to document an unusual medical need to concurrently prescribe benzodiazepines and opioids, which would warrant a prescribing combination that has been shown to present particular risks to patients. Respondent further failed to document attempts to limit or taper either of the categories of drugs for the purpose of patient safety.

12. Patient 2 underwent urine drug testing at Vista on or about August 14, 2018, and on or about August 12, 2019. The test from the August 12, 2019, was negative for benzodiazepines and opioids, although Patient 2 had been prescribed both of these substances. Despite the inconsistencies found on the urine test results, Respondent continued to prescribed oxycodone, morphine and alprazolam. Respondent indicated that he had not reviewed this aberrant result, and had not discussed the matter with Patient 2; nonetheless, he continued prescribing controlled substances to Patient 2.

Patient 3

13. Patient 3 was a 63-year-old man when he began seeing Respondent for medical treatment at Vista during 2018 and 2019. From January 2019 through October 2019, Respondent prescribed Patient 3 a combination of hydrocodone with acetaminophen, oxycodone, and alprazolam. Respondent failed to document an unusual medical need to concurrently prescribe benzodiazepines and opioids, which would warrant a prescribing combination that has been shown to present particular risks to patients. Respondent further failed to document attempts to limit or taper either of the categories of drugs for the purpose of patient safety. Respondent prescribed in excess of 80 milligrams of morphine equivalent per day to Patient 3 during this time, but failed to refer him to pain medication specialist for consultation. Respondent failed to document in Patient 3's records that he tested and reviewed urine drug screens for Patient 3. Respondent failed to document in Patient 3's records that he reviewed the Controlled Substance Utilization Review and Evaluation System (CURES), for Patient 3 to ensure that Patient 3 was not receiving medications from other sources during the time he prescribed to Patient 3.

Patient 4

14. Patient 4 was a 29-year-old man when he saw Respondent for medical treatment at Vista in 2019 with complaints of anxiety. Respondent prescribed sertraline, a non-controlled medication, to Patient 4 for treatment of the anxiety. However, between April of 2019 and January of 2020, Respondent issued six prescriptions to Patient 4, each for a 30-day supply of alprazolam. This amount and duration of benzodiazepine for treatment of anxiety is well in excess of the approved short-term, limited use of benzodiazepines for treatment of acute episodes of anxiety.

Patient 5

15. Patient 5 was a 34-year-old man when he saw Respondent for treatment of attention deficit disorder on or about May 17, 2019. Respondent prescribed Patient 5 a 30-day supply of amphetamine salt combination (Adderall). Respondent did not document Patient 5's vital signs. Respondent documented that Patient 5 had one or more symptoms of inattention, hyperactivity and impulsivity, but did not describe how many symptoms, or which of them were present.

Dishonest Statement to Board Investigator

16. On or about September 21, 2020, after receiving a complaint about Respondent, an investigator working on behalf of the Board traveled to Vista Complete Care, in Auburn, and spoke with Respondent. During their conversation, Respondent told the investigator that he had not been subject to any disciplinary action and had not been told that he was failing to meet expectations during his employment at Vista.

17. Respondent's statement to the investigator was false. Respondent's personnel file showed that he had a large and lengthy disciplinary history with Vista beginning as early as 2016, and continuing through the investigator's visit in 2020. Respondent's personnel file showed that he had been repeatedly advised of infractions by Vista management since at least 2016, including frequent tardiness, failure to complete patient records, multiple patient complaints, and violation of office prescribing policies. Moreover, Respondent had signed many of the disciplinary documents, or provided written statements regarding the disciplinary allegations, thus acknowledging his awareness of them.

18. Vista management issued a formal Disciplinary Decision to Respondent on or about January 17, 2020, based on his failure to comply with office protocols for prescribing controlled substances. Respondent signed the disciplinary decision. On or about July 24, 2019, Respondent signed a disciplinary action, acknowledging that Vista had found he committed various infractions of office polices, such as tardiness, patient care failures, and inadequate documentation. On or about April 1, 2019, Vista management issued Respondent a verbal warning for failing to keep up with his charting. On or about February 1, 2019, Respondent received another verbal warning for violating the Office's policy for prescribing of medications.

19. On or about February 1, 2019, Respondent signed a form acknowledging that he had been found out of compliance with various office policies, such as being late to work, leaving early, and failing to complete a patient prescription before leaving on vacation. In April of 2016, Respondent was placed on a Disciplinary Leave of Absence, without pay, for violations of office policies. Later that month he was placed on employment probation with a requirement that his patient plans be reviewed by a supervising physician.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent is subject to disciplinary action under sections 3527 and 2234, subdivision (b), of the Code in that he was grossly negligent in his care and treatment of Patients 1, 2, and 3. The circumstances are set forth in paragraphs 8 through 13, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

21. Respondent was grossly negligent in his care and treatment of Patients 1, 2, and 3, for his actions or omissions, including but not limited to, the following:

a. Prescribing concurrent benzodiazepines and opioids for several months to Patients 1, 2, and 3, without an unusual medical need for the high-risk combination and without attempting to limit or taper either category of medication; and

b. Prescribing benzodiazepines to Patient 2 for several months while she was 65-years old.

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

22. Respondent is subject to disciplinary action under sections 3527 and 2234, subdivision (c), of the Code in that he was grossly negligent in his care and treatment of Patients 1, 2, 3, 4 and 5. The circumstance are set forth in paragraphs 8 through 19, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

23. Respondent was repeatedly negligent in his care and treatment of Patients 1, 2, 3, 4, and 5, for his actions or omissions, including but not limited to, the following:

a. Prescribing concurrent benzodiazepines and opioids for several months to Patients 1, 2, and 3, without an unusual medical need for the high-risk combination and without attempting to limit or taper either category of medication;

b. Prescribing benzodiazepines to Patient 2 for several months while she was 65-years old;

c. Continuing to prescribe controlled medications to Patient 1 and 2 despite inconsistent drug testing and without documenting or addressing the inconsistencies;

d. Failing to refer Patients 2 and 3 to a specialist despite their medication regimen which consisted of Daily Morphine Equivalent doses in excess of 80 milligrams;

e. Failing to check and document CURES reports for Patient 3;

f. Prescribing long-term courses of benzodiazepine to Patient 4 for treatment of anxiety; and

g. Prescribing a 30-day course of a controlled stimulant to Patient 5 without adequate documentation of the basis for the prescription.

THIRD CAUSE FOR DISCIPLINE

(Dishonest Act Related to the Practice of Medicine)

24. Respondent is subject to disciplinary action under sections 3527 and 2234, subdivision (e), of the Code in that he committed a dishonest act related to the practice of medicine. The circumstances are set forth in paragraphs 8 through 19, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

25. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2234, in that Respondent conducted himself in a manner unbecoming a medical professional as alleged in Paragraphs 8 through 19, which are incorporated by reference as if fully set forth here.

DISCIPLINARY CONSIDERATIONS

To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about February 15, 2013, Respondent sustained disciplinary action in a prior licensing matter before the Board. In an action entitled, "In the Matter of the Statement of Issues Against Jason Alan Berryhill for a Physician Assistant License before the Physician Assistant Board, Medical Board of California[1], in Case No. 1E-2012-223249", Respondent's application for a Physician Assistant license was granted, but immediately revoked, with the revocation stayed. Respondent's new Physician Assistant License PA 22877 was placed on probation for a period of three years with certain terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physician Assistant Board issue a decision:

1. Revoking or suspending Physician Assistant License Number PA 22877, issued to Jason Alan Berryhill, P.A.;

2. Ordering Jason Alan Berryhill, P.A., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

3. Taking such other and further action as deemed necessary and proper.

[1] At the time of the Decision, the Physician Assistant Board was an agency within the Medical Board of California.

DATED: November 17, 2022

Rozana Khan

ROZANA KHAN
Executive Officer
Physician Assistant Board
Department of Consumer Affairs
State of California
Complainant

SA2022302133